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ABSTRACT

The document is the second volume of a four-part report of a study conducted to evaluate and assess the national state of clinical education and training of allied health manpower. It contains the appended materials of the study and includes the following: (1) approach and mechanisms of the study--selected occupations, areas of inquiry, information gathering design, and data analysis; (2) site visit methodology--selection criteria and coverage within sites; (3) interaction with professional associations--types of contacts and a listing of professional associations providing input; (4) glossary of terms; and (5) position statements on allied health credentialing by the Accreditation and Institutional Eligibility Staff, Office of Education (DHEW); American Hospital Association; American Medical Association; Association of Schools of Allied Health Professions; Division of Allied Health Manpower, Bureau of Health Resources Development (DHEW); Division of Medical Care Standards, Health Resources Administration (DHEW); Federation of Regional Accrediting Commissions on Higher Education; and National Commission on Accrediting. (EC)

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Volume II

Appendixes
National Assessment of Clinical Education of Allied Health Manpower

(Contract NO1-AH-24345)

HEALTH RESOURCES ADMINISTRATION
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Washington, D. C.

August 30, 1974

This report is of a confidential nature and intended solely for the information of the client to whom it is addressed and the Task Force on Allied Health Clinical Education.

CE007053

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APPENDIX A

APPROACH AND MECHANISMS OF THE STUDY

The approach adopted for the study was designed to ensure in-depth investigation of issues crucial to clinical education across occupations. It also provided for consideration of relationships between clinical education and other educational components. Finally, the approach was structured to take into account prevailing principles and trends in education, health care, and management.

The methodology, in turn, was designed to achieve the following related objectives:

- An assessment of clinical education incorporating a synthesis of divergent viewpoints
- Collection of comprehensive and accurate information related to important issues
- Distillation of the information to produce meaningful results and appropriate recommendations

1. SELECTED OCCUPATIONS PROVIDED A POINT OF DEPARTURE FOR THE GENERIC APPROACH OF THE STUDY

In-depth investigation of the numerous disciplines comprising allied health was an impossibility within study resources--no matter whose definition of allied health was used. It was therefore decided that certain occupations would be identified for major emphasis although the study would be concerned largely with generic issues.

Eighteen occupations were selected for primary emphasis on the basis that they:

- Represent a mix of established occupations and those with an evolving status
- Require an organized educational program

These occupations are listed in Exhibit A-I, following this page. Not withstanding this emphasis, a number of other occupations were also considered in some depth. These occupations included, among others:

- Corrective Therapy
- Cytology
- EEG Technology
- Emergency Medical Technology
- Histologic Technology
- Orthotics and Prosthetics
- Speech Audiology and Pathology

EXHIBIT A-I

OCCUPATIONS SELECTED FOR EMPHASIS

Certified Laboratory Assistant

Dietician

Dietetic Technician

Medical Assistant

Medical Laboratory Technician

Medical Record Administrator

Medical Record Technician

Medical Technologist

Occupational Therapist

Occupational Thereapy Assistant

Operating Room Technicians

Optometric Technologist

Optometric Technicians

Physical Therapist

Physical Therapy Assistant

Radiologic Technologist

Respiratory Therapist

Respiratory Therapy Technician

All occupations were investigated within the framework of the allied health educational continuum and major areas of study inquiry as described in the following section.

2. MAJOR AREAS OF INQUIRY WERE DEFINED AS A FRAMEWORK FOR INVESTIGATION AND ANALYSIS

The framework for identifying major areas of inquiry and classifying the issues to be examined was developed in detail. The following subjects were established as the major areas of study inquiry based on their importance to clinical education today and relevance to the scope of work:

- Management
- Financing
- Manpower and physical resources
- Students
- Content
- Standards and credentialing

Issues associated with each area were then assessed in the following terms:

- Criticality to the efficiency and effectiveness of clinical education
- Suitability to analysis in a generic context
- Potential for development of meaningful recommendations

The following paragraphs describe the major areas of inquiry. The issues selected for detailed study are also presented.

(1) Planning, Organization, and Control of Clinical Education Within a Two-Party Context Provided the Structure for the Investigation of Management Issues

Management traditionally involves planning, organization, operation, and control. These functions provide a means to structure and coordinate diverse activities to achieve identified ends.

In investigating the contribution of these functions to the efficiency and effectiveness of clinical education, program sponsors and affiliating agencies received major attention.

The investigation was structured in terms of the following basic concerns:

- Factors considered in program establishment
- Management structure of clinical education
- Operational interface between affiliated institutions
- Operational control of clinical education

Subsidiary questions addressed the positions and contributions of the two partners in clinical education. These questions are outlined in Exhibit A-II, following this page.

(2) Concern With Financing for Clinical Education Necessitated Consideration of Participant Costs and a Cost-Finding Methodology

The basic question regarding the financing of clinical education was: How can clinical education be financed with greatest efficiency and effectiveness? Identification of effective approaches necessitated examination of the following related aspects:

- Suitability of different funding sources
- Identification of the generic costs and benefits of providing clinical education
- Development of a methodology for identifying and allocating costs and benefits between program sponsors and providers of clinical education

Specific questions addressed within this area of inquiry are listed in Exhibit A-III, following Exhibit A-II.

(3) Consideration of Manpower and Other Resources To Support Clinical Education Concentrated on Their Availability and Utilization

Financial and other resources were treated separately because of their inherent differences. Manpower and other

EXHIBIT A-II

QUESTIONS FOR THE STUDY IN THE MANAGEMENT OF CLINICAL EDUCATION

Why are allied health programs established, and what factors are considered in the planning process?

What conditions lead to program establishment?

What information was available and used in establishing the program?

- Employer demand data?
- Student demand data?
- Other?

Who were the prime movers?

How were objectives formulated and coordinated for:

- Educational institutions?
- Health care agency?
- Programs?

What parts do the sponsoring institution and the affiliating institutions play in the conduct and operation of the clinical education program?

- What role and responsibility does each participant have?
- What is the nature of the agreement between the participants?

How are the following activities accomplished:

- Monitoring of agreement?
- Evaluation of program?
- Implementation of required changes or improvements?

How do the participating institutions coordinate the joint activity?

How is the program controlled to ensure that it operates as planned?

EXHIBIT A-III (1)

QUESTIONS CONSIDERED IN THE FINANCING OF CLINICAL EDUCATION

To what extent should education institutions be responsible for financing clinical training with funds from such sources as:

- Federal Government
- State/local government (tax base)
- Industry
- Private endowments
- Student tuition and fees

To what extent should health care facilities and agencies be responsible for financing clinical training with funds from such sources as:

- Government (tax base)
- Private endowments
- Direct patient charges
- Third-party charges
- Student charges

What should students pay for clinical education?

If a subsidy is necessary, should it be part of a general education or special program subsidy?

What are the cost and benefit (service rendering) elements of allied health clinical training?

- Should cost equivalents be established for benefits to the health care agency from clinical training and these costs be treated as service costs?
  - Service to patients
  - Support staff development
  - Support of personnel recruitment, selection, orientation, and retention
  - Professional status
  - Community relations
- Should estimated replacement costs be a basis for deriving these cost equivalents?

What direct and indirect costs does the health care agency incur for clinical education, and how should these be valued?

- Personnel
- Equipment
- Overhead and maintenance

What direct and indirect costs does the sponsor of the basic occupational program incur for clinical education, and how should these be valued?

Is the concept of gross and net educational costs for clinical education an appropriate allocation methodology?

resources were approached from the viewpoint of the need to maximize availability and utilization. At the same time, the close relationship between the two areas was recognized.

As the basis for investigating this area of inquiry, three groups of resource elements were defined in addition to personnel:

- Facilities and equipment
- Instructional aids
- Clinical patients and patient material

The analysis was structured around the following:

- Institutional characteristics which affect personnel and other resources
- Characteristics of resource elements which promote or impede resource availability
- Possible avenues for improving resource availability or utilization

The specific issues explored are listed in Exhibit A-IV, following this page.

(4) The Investigation of Content Addressed the Philosophy and Objectives of Content As Well As Its Determination and Implementation

Content was defined for this study as the body of knowledges, skills, judgments and attitudes which an allied health worker should develop to provide safe,

EXHIBIT A-IV (1)

QUESTIONS INVESTIGATED REGARDING MANPOWER AND OTHER RESOURCES FOR CLINICAL EDUCATION

What is the association between institutional characteristics and the availability of resources for clinical education?

- What are the effects of different levels of allied health health programs, e.g., baccalaureate, associate degree, diploma, and certificate, on resources?
- Do requirements associated with other health education programs, e.g., nursing and medicine, affect resources for allied health clinical education?
- How does institutional sponsorship affect resources?
  - Upper level collegiate institutions with medical centers
  - Colleges and universities without a medical center offering one- to four-year programs
  - Health services institutions
  - Combinations of the above
- What differences in resource availability and utilization are associated with clinical facility characteristics such as:
  - Type?
  - Location?
  - Objectives and policies?
  - Atmosphere?

What are the characteristics of resource elements?

- Is space available within health care agencies for:
  - Instruction and patient service?
  - Accommodations for students, e.g., classrooms, libraries, study areas, etc.
- What effects do the currency and quality of health care proveded by an agency have on clinical education?

- Do individual staff have the capabilities to provide clinical instruction and serve as role models?

- Are clinical units able to provide instruction and meet service requirements in light of:

  - Staff organization, assignments, and responsibilities?
  - Service demands and instructional responsibilities?
  - Attitudes toward providing instruction?
  - Incentives for providing instruction?

- Is the treatment equipment required for instruction available and adequate in terms of:

  - Variety?
  - Currency?
  - Access for instruction?

- Are instructional equipment and aids available and adequate:

  - In the clinical facility?
  - In the educational institution?

- Are clinical patients and patient material available and adequate relative to program requirements?

How can we improve resources for clinical education?

- How can the capacity of currently unused facilities be realized?

- What improvements in utilization can be realized?

  - Coordinate information on requirements and availability

  - Coordinated and expanded use of avilable resources

- How can educational capabilities of clinical facilities be expanded?

efficient and humane care. Based on this definition, a philosophy to govern clinical education was developed.

This philosophy provided the context for investigation of the following major issues related to content:

- What are the objectives of clinical education?
- Who should determine clinical content?
- What methods should be used in developing content for clinical education?
- How should content be implemented?

Exhibit A-V, following this page, identifies particular questions that were considered.

(5) The Investigation of Standards and Credentialing Focused on Striking a Balance Between Assuring Competency and Avoiding Limitations on Clinical Education

This area of inquiry covered three of the four processes embraced within the term "credentialing." These processes were defined as follows for the study:

- ACCREDITATION is the process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study or their services.

EXHIBIT A-V

QUESTIONS INVESTIGATED REGARDING
THE CONTENT OF CLINICAL EDUCATION

What should students be exposed to in their clinical education?

What options are available for different students?

How is content determined? By whom? How frequently?

What is the role of professional associations in these processes?

How does content relate to:

- Accrediting bodies?
- Certification requirements?
- Licensure?

What interfaces exist between the practicum and the didactic? How can these be made most effective?

What contacts and feedback exist between the marketplace and the educators? When are these contacts made? Is the government playing a role in this area?

What mechanisms exist to make adjustments brought about by technological advances?

- Social
- Organization

Are they used?

What are the relationships between education, proficiency, and progress?

How are distinctions made between education and services? How much service should be included?

What is the role for simulation?

What variety of experiences, both in settings and types of activities, should be included in the practicum?

- CERTIFICATION is the process by which a nongovernment agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

- LICENSURE is the process by which an agency or government grants permission to persons meeting predetermined qualification to engage in a given occupation and/or use a particular title or grants permission to institutions to perform specified functions.

The investigation of standards and credentialing operated on two basic premises:

- Some means should be available to ensure the competency of allied health practitioners and thereby promote the health and safety of the public.

- Credentialing standards, regulations, and their enforcement inherently have a constraining effect which should be minimized where the efficiency and effectiveness of clinical education are impaired.

These premises provided the foundation for identifying the detailed subjects covered in the investigation. These subjects are listed in Exhibit A-VI, following this page.

(6) Student Input to Clinical Education Was of Primary Concern in the Sixth Major Area of Inquiry

Students were identified as the desirable crux of clinical education. At the same time, it was hypothesized that the students' pivotal role often is not recognized.

EXHIBIT A-VI

QUESTIONS FOR STUDY IN THE INVESTIGATION OF STANDARDS AND CREDENTIALING

What are the effects of various aspects of the credentialing mechanisms on clinical education of allied health occupations?

- Purpose
- Requirements and standards
- How developed
- How implemented

What are the ways in which credentialing reduces or limits the effectiveness and efficiency of clinical education?

How is competency defined? How should it be defined? Who defines it?

Once competency is defined, what are the most effective and efficient approaches to determining the existence of competency?

What is the extent to which these approaches:

- Obviate the need for other credentialing mechanisms?

- Require incorporation into a particular credentialing mechanism?

What is the approach that can be implemented to resolve major problems pertinent to credentialing?

What are the proper roles for various organizations regarding credentialing:

- Government?
- Professional and/or education associations?
- Representatives of consumers and/or public?
- Employers?
- Educational institutions?
- Instructional aids and their application:

  - Development
  - Use

How can the "clinical capabilities" of educational activities be expanded?

A major concern of this area of inquiry was investigation of student input to the clinical process. The impact of clinical education on students also was of concern, as were institutional processes related to students. Specific subsidiary concerns are outlined in Exhibit A-VII, following this page.

3. THE STUDY DESIGN PROVIDED VARIOUS MEANS OF GATHERING INFORMATION

The basic methodology for assessing clinical education was designed to achieve development of an expert consensus, if possible, regarding the present state of allied health clinical education, impediments to its efficiency and effectiveness, and approaches to removal of identified impediments.

This consensus was developed through the refinement of information from multiple sources and permitted incorporation of the perspectives and insights of different participants in allied health education. In turn, consideration of this information by authorities in allied health and education helped ensure the validity of the study conclusions. The interdigitation of this collective expertise also contributed to the development of appropriate recommendations.

EXHIBIT A-VII

QUESTIONS INVESTIGATED REGARDING STUDENTS

How do institutional processes relate to students, specifically:

- Recruitment and admissions?
- Guidance and counseling?
- Provision for student subsistance?

What is the student input to the clinical process through:

- Evaluations?
- Clinical practicum services?

What is the clinical training impact on the student?

- Completion of education?
- Placement and employability?
- Mobility and career development?

Five methods were used in collecting, analyzing, and refining information:

- A task force of authorities in allied health manpower
- Subcommittees of the task force with participation by additional experts
- Site visits
- Resource information survey including:
  - Inputs from allied health professional associations, other concerned organizations, and resource persons
  - Review of completed and ongoing studies
- Monograph treatment of special topics

The contributions of each mechanism are described in the following paragraphs.

(1) The Task Force Provided a Vehicle for Final Consensus

A 15-member task force comprised of authorities in health education, clinical administration, and related fields was established. These experts provided advice on the structure and performance of the assessment and focused major attention on study findings and recommendations. The names of task force members and their current affiliations are listed

in Appendix B. The following paragraphs describe the composition and functions of the task force.

Task force members were representative of institutional and special concerns in allied health education. No attempt was made to provide for occupational representation on the task force since it would have been impossible to achieve comprehensive representation within a small group of working size. Further, the generic nature of the study made it undesirable to accentuate occupational uniqueness.

Alternatively, task force members were selected to represent the primary participants in clinical education. The major categories of health manpower were also included on the task force, i.e., medicine, dentistry, and nursing, as well as allied health. In addition, the composition of the task force recognized the expansion of minority participation and geographic variations. Finally, provision was made for specialized expertise regarding credentialing and the experience of the military.

All members of the task force are recognized authorities in their own right in the health manpower field.

The task force, therefore, provided a variety of outlooks and a wealth of knowledge and experience to support the study.

Support in developing the framework and procedures for the detailed investigation of allied health clinical training was provided by the task force on a group basis. The task force also contributed individually and as a group to the implementation of the study.

The task force was instrumental in study design by delineating parameters of clinical education within the educational continuum and defining the six major areas of inquiry and primary subsidiary issues.

Contributions by the task force to the performance of the study included:

- Identification of information resources and provision of data
- Participation by members in the site visits
- Direction of and participation in the work of the subcommittees

(2) Subcommittees of the Task Force Directed Their Attention to Particular Areas of Inquiry

Six subcommittees were established as the working groups of the task force. Each subcommittee concentrated its investigation on one of the major areas of inquiry. The subcommittees were composed of task force members augmented by 18 additional experts. The names of the subcommittee members and their affiliations are provided at the beginning of this report. The following paragraphs describe subcommittee composition and activities.

Inclusion of two to four experts on each subcommittee in addition to task force members increased the expertise that could be brought to bear in each area It also introduced additional diversity of perspective and outlook.

Subcommittee members were primarily drawn from educational and clinical settings. Subcommittee candidates also had demonstrated expertise and interest related to their major area of inquiry. Some members were therefore drawn from specialized activities, such as health education planning and development of occupational examinations.

Having identified specific issues, each subcommittee concentrated on problems and possible approaches within a major area of inquiry. Task force members served as chairmen and vice chairmen of the subcommittees and introduced the issues and concerns identified for subcommittee consideration. These issues were refined and extended for the subcommittee investigations.

Working within the boundaries of the defined issues, the subcommittees divided their attention among:

- Identification of specific questions to be answered in the investigation
- Review of findings developed by the study staff
- Development of a consensus based on study findings and members' experience on:
  - Factors detracting from educational efficiency and effectiveness in clinical settings as related to the major area of inquiry
  - Avenues to improving conditions for developing clinical knowledge, skills, and attitudes of allied health students in the short and long term

A report was prepared detailing each subcommittee's scope of discussions and its suggestions regarding the current situation in the area of inquiry, major deficiences, and

suggestions for enhancing clinical education. These reports were then presented to the task force for its review and analysis.

(3) Site Studies Provided a Means To Review Clinical Education at Different Levels of Program Operation

The necessity of obtaining information on clinical education from an operational viewpoint was recognized in the study work statement. In-depth investigation of 40 specific allied health education programs at 6 geographically dispersed locations provided a vehicle for:

- Eliciting opinions of individuals involved in the day-to-day decisions and activities of program operations. These viewpoints provided an additional dimension to those of persons approaching clinical education from a particular subject matter orientation or national outlook.
- Developing an empirical description of the operational mechanics, organizational structures, funding and financial systems, administrative procedures, and other factors associated with clinical education systems. This description provided a baseline that was refined and extended through other study mechanisms.

The following paragraphs briefly outline the scope of the site visits. Further details are provided in Appendix B.

- Sites Were Defined To Encompass Major Related Clinical Education Systems Within a Community--For the purpose of this study, a site was defined as an institution within its community setting.

More specifically, a site was made up of an educational or health care agency which is responsible for three or more allied health programs and related health care and educational activities in the community. This approach was designed to capture the variability among sites indicated by preliminary exploratory visits to educational institutions and health care agencies.

The clinical education system defined for a community therefore encompassed program sponsors and providers of affiliations, as shown in Exhibit A-VIII, following this page. The exhibit also shows that the system included organizations with an influential although indirect role in clinical education.

The Site Visits Provided Representative Coverage of Clinical Education Operations--The study sites were selected to provide a broad mix of institutional types, organizational arrangements, and geographic variations. The characteristics of the six sites are identified in Exhibit A-IX, following Exhibit A-VIII.

A list of the occupations for which clinical education was investigated at these sites is provided in Exhibit A-X, following Exhibit A-IX. In summary, the site visit coverage included:

- 40 different basic occupational programs of a year or more duration
- 17 educational agencies
- 40 health care agencies

Further details of the coverage are provided in Appendix B.

Special Site Visits and Volunteers' Provision of Input Expanded the Information Collected--Abbreviated visits were made to a four-year college and a medical school-state university complex in the Southeast. Both of these institutions

EXHIBIT A-VIII

CLINICAL TRAINING NETWORK IN STUDY SITES

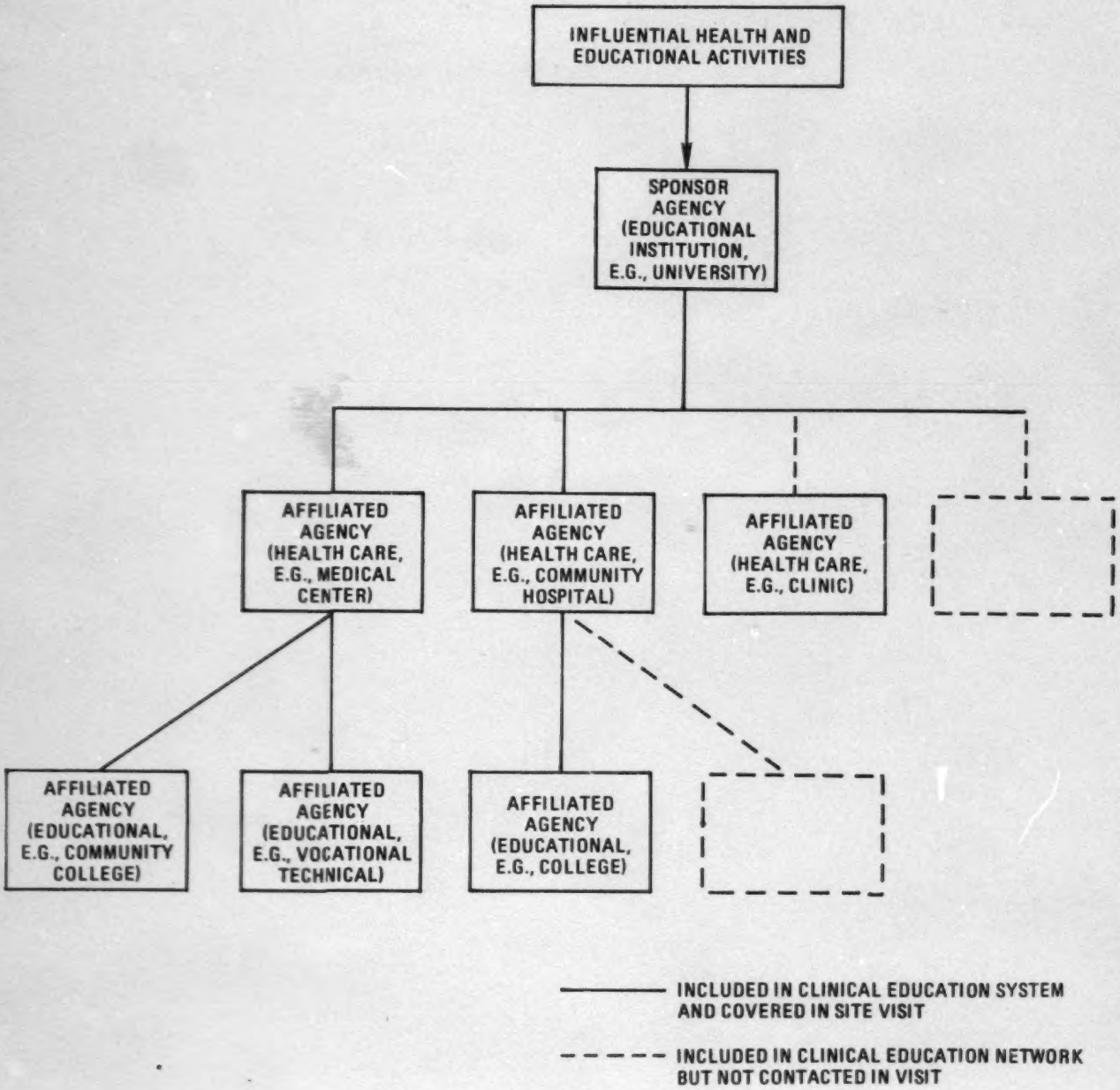
INFLUENTIAL HEALTH AND EDUCATIONAL ACTIVITIES
SPONSOR AGENCY (EDUCATIONAL INSTITUTION, E.G., UNIVERSITY)
AFFILIATED AGENCY (HEALTH CARE, E.G., MEDICAL CENTER)
AFFILIATED AGENCY (HEALTH CARE, E.G., COMMUNITY HOSPITAL)
AFFILIATED AGENCY (HEALTH CARE, E.G., CLINIC)
AFFILIATED AGENCY (EDUCATIONAL, E.G., COMMUNITY COLLEGE)
AFFILIATED AGENCY (EDUCATIONAL, E.G., VOCATIONAL TECHNICAL)
AFFILIATED AGENCY (EDUCATIONAL, E.G., COLLEGE)
INCLUDED IN CLINICAL EDUCATION SYSTEM AND COVERED IN SITE VISIT
INCLUDED IN CLINICAL EDUCATION NETWORK BUT NOT CONTACTED IN VISIT

EXHIBIT A-IX (1)

CHARACTERISTICS OF STUDY SITES

City-operated community college in a major eastern urban center which:

- Sponsored seven programs of interest, the majority of which awarded associate degree
- Had affiliations for clinical education with over 18 health care agencies in the adjacent area*
- Was participating in the establishment of a consortium

Private hospital in a major eastern urban center which:

- Provided clinical affiliation for eight programs of interest sponsored by:
  - Adjacent and remote four-year colleges
  - Adjacent community colleges
- Sponsored two programs of interest

Public vocational-technical school in a small midwestern city with regional accreditation as a junior college which:

- Sponsored six programs of interest, both certificate and associate degree
- Had clinical affilations with over 20 health care agencies 7 of which were in the same city
- Related to a major university health science center in the community in various ways, including its provision of:
  - Clinical affiliations
  - Advisory committee members
  - Continuing education

College in a medium-sized southeastern city which:

- Was part of a university health sciences center

* Selected agencies were visited, which included discussions with agency sponsored programs.

- Sponsored three programs of interest at the baccalaureate level
- Had affiliations with over 15 health agencies including the center hospital
- Was related to a community college system sponsoring three programs of interest
- Operated a Allied Health Instructor Preparation (AHIP) center receiving W. K. Kellogg Foundation funding

College in a medium-sized southwestern city which:

- Was part of a university health sciences center
- Sponsored five programs of interest at the baccalaureate and associate degree levels and was in the process of establishing a sixth program
- Had affiliations with over 15 health agencies in the adjacent area including the medical center
- Participated in formal and informal efforts to coordinate its programs with the health education programs of two junior colleges in the community as well as other resources across the state

Community college in a major west coast city which:

- Sponsored five programs of interest, primarily at the associate degree level, and was developing a sixth program
- Had affiliations with over 20 health care agencies in the adjacent area
- Was extensively involved in continuing education

EXHIBIT A-X

BASIC OCCUPATIONAL PREPARATION PROGRAMS
INVESTIGATED IN SITE VISITS

Bioengineering technology
Cardiopulominary technology
Certified laboratroy assisting
Cytotechnology
Dietetics
Dietary technology
Electronencphelography technology
Emergency medical technician
Histotechnology
Medical assistant
Medical laboratory technology
Medical records administration
Medical records technology
Medical technology
Nuclear medicine technology
Occupational therapy
Occupational therapy assistant
Optemetric technology
Physical therapy
Physical therapy assisting
Radiologic technology
Respiratory therapy
Respiratory therapy technology
Speech pathology and audiology

are popularly classified as "black schools." The purpose of these visits was to obtain descriptive information and opinions from the "black school" perspective.

Additional information was provided in the form of written input supplied by volunteers. These volunteers included persons involved in clinical education in rural settings, thereby ensuring coverage of such programs.

(4) The Resource Information Survey Relied Upon Knowledgeable Individuals As Well As the Literature

The resource information survey was to develop information to supplement and complement that provided by other input mechanisms. The following types of information were of particular importance:

- Specifics associated with clinical education for particular occupations
- Trends across occupations, including:
  - Common problems and their incidence
  - Implementation and success of changes
- Developments that gave promise of alleviating current weaknesses

The survey results have been documented in an annotated bibliography of completed and ongoing studies bearing on clinical training. Abstracts of significant studies have also been developed. These outputs are found in Volume III,

Parts A and B, respectively. This section describes key points of the resource information survey; additional details are found in Volume III.

Opinions of individuals involved in allied health education were of major importance since knowledgeable individuals often provide more specific current and in-depth insights than can be obtained from the literature. The resource information survey therefore included contact with persons active in allied health professional association activities, particularly those affecting education and with persons identified as having expertise related to particular study concerns, e.g., the application of task analysis to identify educational objectives.

The focus of the resource information survey was clinical training in allied health. To obtain the types of information identified above, the survey scope was extended in the following directions:

- Information was collected dealing with related components of the education-employment continuum, such as general instruction.
- Developments in other health fields were investigated where they appeared to have applicability, for example, the use of autio-tutorial techniques in clinical education for nursing.

This extension was primarily applicable to the selection of documentary materials. In some cases, contacts with knowledgeable individuals were also governed by this expanded scope.

The six major areas of inquiry provided an initial basis for the selection and categorization of documentary materials. These materials included the range of published and unpublished works, i.e., books and journals to dissertations, as detailed in Volume III. The nature of the materials led to an expansion of the areas of inquiry. Two additional categories were created, namely:

- General--To accommodate materials that could not be meaningfully categorized in terms of a single area of inquiry
- Continuing Education--To reflect the specialized nature of studies dealing with this topic

The steps implemented in collecting and extracting documentary materials were:

- Identification and selection
- Classification and review
- Annotation and abstracting

Further details are provided in Volume III.

A number of ongoing studies dealing with allied health education were identified. These studies were researched through:

- Review of available documentary materials
- Contacts with principal investigators

These contacts provided the information to complete reviews of the studies, as discussed in Volume III.

The important role of allied health professional associations dictated the involvement of other organizations representing the major allied health occupations. Contacts also were made with other professional associations and organizations exerting important influences on clinical education. Such organizations include the American Medical Association, the American Hospital Association, and the Association of Schools of Allied Health Professions. Appendix C lists the associations contacted.

The following approaches provided a means to obtain information and opinions from the associations:

- Solicitation of input in an initial letter of notification
- Professional association forum

- Contributions from and discussions with association representatives

Appendix C provides additional details on these contacts.

References to persons active in education of a particular occupation, to individuals with subject area expertise, and to government officers responsible for the monitoring and support of health-related education and training were identified through:

- Task force and subcommittee recommendations
- Site visits
- Association contacts
- Previous Booz, Allen studies

Study resources did not permit in-depth contacts with all individuals identified as experts. Nominees for contact were screened in conjunction with the Project Officer.

Discussions were directed to individual experts' areas of concentration. Opinions regarding other parameters of clinical education and general trends were also elicited as appropriate.

(5) Four Monographs Have Been Prepared Which Explore Specialized Aspects of Present Clinical Education and Avenues for Change

The four monographs commissioned as part of this study have been designed to meet two objectives:

- Provide concentrated in-depth analysis by recognized authorities of discrete issues which are complex or controversial in nature
- Augment other collection and analytical mechanisms through the provision of this specialized information

The contractual scope of work identified a number of potential subjects for monographs. In considering these topics, the task force defined additional issues thought to merit monograph treatment. Results of the resource information survey and the early site visits were also factored into the selection process. Contacts with authorities identified as author candidates provided an additional source of input.

The following four topics were selected as the subjects for monographs by the individuals listed:

- "Internship as an Alternative/Adjunct to Clinical Training" (Dr. M. Harty)
- "Methods of Ensuring Quality in Clinical Training" (R. Allen)

- "Relationship of Allied Health and Nursing Clincal Training" (Dr. E. Flynn)

- "Simulation as an Alternative/Adjunct to Clinical Training" (Dr. T. Scheller)

The treatment of each subject was refined in a series of contacts between the authors and the study team. The complete monographs are presented in Volume II of this report.

4. INFORMATION COLLECTED WAS ANALYZED IN A SERIES OF SEQUENTIAL STEPS TO SUPPORT TASK FORCE DELIBERATIONS

The purpose of these information gathering efforts was to provide a broad perspective on the present situation in clinical education for task force consideration. To achieve this goal, the study team analyzed the information in four iterative steps. The analysis process is described in the following paragraphs.

(1) Site Information Was Analyzed To Identify Organizational and Operational Patterns Characteristic of Clinical Education

Each site visit covered the following aspects:

- Overall organization and important interfaces of the clinical training network

- Organization of clinical education within educational and health care agencies

- Important factors in the operation of clinical education in these agencies

- Noteworthy differences in organization and operation by:

  - Type of agency and role
  - Occupation

- Problems experienced in providing clinical education by:

  - Type of agency and role
  - Occupation
  - Respondent category

- Suggestions for alleviating current difficulties by:

  - Type of agency and role
  - Occupation
  - Respondent category

These analyses were conducted within the framework of the major areas of inquiry. Two roles were defined for educational institutions and health care agencies: program sponsors and affiliated agency.

Findings regarding individual sites were compared across sites to identify:

- Commonalities among sites by:

  - Type of agency and role
  - Occupation
  - Respondent as appropriate

- Differences among sites

- Other contributory factors

Because of the generic emphasis of the study, commonalities received major attention.

(2) The Information Obtained From Associations and Other Experts Indicated National Trends and Developments

Descriptive data and personal insights collected from association staff and resource personnel also were extracted by major area of inquiry. Specialized subjects were of particular importance, such as:

- Behavorial and performance objectives
- Curriculum design and development
- Instructional aids and materials
- Organization and operation of credentialing

This information was analyzed to identify national trends and developments. In addition to commonalities, differences associated with particular occupations were identified.

(3) The Resource Information Survey Provided Further Review of Special Topics

Literature and ongoing studies concerned with clinical education are limited in number. A greater number specifically treated didactic and clinical education. Within this group, a majority concentrated on didactic instruction dealing with clinical education as a necessary adjunct.

Education was merely one topic in many of the items reviewed. Relevant materials were largely exhortative, descriptive, reviews of other efforts, or case studies. The survey results were therefore primarily used for corroboration of findings developed from other data, examination of special topics, and investigation of trends.

Information regarding special topics was analyzed from two viewpoints: (1) determination of the current state-of-the-art and (2) identification of the potential for change and innovation.

Trend information was investigated to (1) determine developments affecting allied health or specific occupational areas with ramifications for clinical education and (2) ascertain indicators of potential for particular approaches in improving efficiency and effectiveness.

(4) The Findings Derived From These Analyses Were Integrated for Consideration By Each Subcommittee and the Task Force

Each subcommittee had identified a number of questions for investigations within each major area of inquiry (presented in Exhibits A-II to A-VII). Findings from the

site visits were integrated with those regarding national trends and developments to respond to questions posed by the subcommittees.

In this analysis, peculiarities of individual occupations were eliminated from consideration. Significant program and occupational characteristics were retained for subsequent analysis. The status of clinical education and generic limitations were documented by major areas of inquiry, as were alternative approaches to alleviation of present difficulties.

These results were reviewed with each subcommittee, and reactions were incorporated into subsequent analysis. Particular emphasis was given to the subcommittee refinement of problem statements and recommendations. Finally, task force reactions to the findings within each area of inquiry were incorporated into the analysis underlying preparation of this report.

SITE VISIT METHODOLOGY

I. SELECTION CRITERIA

Six sites, as defined in Appendix B, were visited to obtain information on clinical education operations and the insights of allied health clinicians and educators conversant with program details. The sites were selected to provide diversified and comprehensive coverage using criteria developed on the basis of the contractual scope of work, initial investigations, and task force input.

1. INFORMAL EXPLORATORY VISITS CONFIRMED THE VARIABILITY OF CLINICAL EDUCATION

As an initial study activity, visits were made to adjacent educational institutions and health care agencies engaged in allied health clinical education. These visits included programs at all educational levels of interest in Washington, D.C., and in Maryland, Delaware, Pennsylvania, and Virginia. Informal discussions were held with personnel involved in the didactic and practicum modes of clinical instruction. Individuals responsible for program and institutional management were also contacted.

These discussions highlighted organizational and operational differences among programs and institutions with respect to clinical education. The information was useful in refining the site selection criteria outlined in the scope of work.

2. TASK FORCE INPUT WAS SOUGHT FOR SELECTION CRITERIA AND SITES

Site selection criteria were reviewed by the task force who provided valuable comments. Final criteria used for site selection are shown in Exhibit B-I, following this page. The task force then suggested names of specific sites which could be considered for visits. The characteristics of the six sites visited were shown in Exhibit A-IX.

EXHIBIT B-I

CRITERIA FOR SITE SELECTION

One of each type of postsecondary education institution should be a primary institution; i.e., 4-year college, 2-year junior college, and vocational technical school.

One site should be a health care agency as the primary institution.

Sites should provide for investigation of a maximum number of programs for the occupations selected for intensive study.

Sites should be selected from communities in different regions of the country with varying demographic characteristics.

Sites should provde for the following attributes:

- Mix of educational institutions within the clinical education network
- Variety of organizational arrangements, for example, use of adjacent and remote affiliations or involvement in a consortium

II. COVERAGE WITHIN SITES

Within a site or community, the organization sponsoring the programs was designated as the primary institution. The primary institution provided the focal point for defining related institutions in the community clinical education system. These organizations included:

- Health care agencies providing the clinical education for programs sponsored by the educational institution. Other clinical education affiliations as well as any programs sponsored by these agencies were also investigated.
- Educational institutions within the community providing didactic instruction for programs investigated within a health care agency.
- Supportive organizations such as formal or ad hoc groups responsible for health and educational planning and coordination, for example, boards of regents, health education consortia, etc.

1. COVERAGE WITHIN A SITE VARIED DEPENDING ON THE CONFIGURATION OF THE CLINICAL TRAINING NETWORK, PROGRAM ACTIVITY, AND LOCAL RESOURCES

In each site, the study team held an initial meeting with the chief administrator of the primary institution. These meetings provided an opportunity to "flesh out" preliminary information on the community clinical education system. The insights of the administrator were also obtained.

The coverage of affiliated institutions--educational and health--was selective rather than exhaustive. Programs and activities were chosen to provide a comprehensive mix of agency types and organizational relationships. Public and private health care and educational agencies of various types and sizes were included. Agencies providing secondary clinical affiliations, i.e., limited experience in special areas, were contacted. The characteristics of an agency's affiliations and programs were also considered, for example, occupation, number of students, and mix of students by educational level as appropriate.

2. DISCUSSIONS WITH A WIDE RANGE OF PERSONNEL FOLLOWED A GENERALIZED PROTOCOL

A generalized protocol was used to assure minimum comparability of information and opinions across programs, agencies, and sites. Within this framework, the discussion participants differed in:

- Their willingness to express opinions
- Their opinions of the
  - Current status of clinical education
  - Possible improvements

Loosely structured discussions were conducted with program personnel and administrators. Administrative personnel contacted included chancellors of health science centers and

comptrollers. Exhibit B-II, following this page, indicates the nature of personnel contacted for program information and their opinions. Record data were also reviewed as appropriate.

Discussions with students were conducted on a group basis. Some of these conversations drew students preparing for different occupations. In other instances, the group was made up of students drawn from the same program.

The nature of the supportive organizations within a community dictated the possible coverage. Within this category, discussions were held with:

- Chancellors and other members of the university or college regents system
- State directors of vocational and technical education and health occupations specialists
- Personnel of Comprehensive Health Planning and Regional Medical Program agencies
- Staff of specially convened task forces and study groups
- Individuals involved in health education consortia

EXHIBIT B-II

CATEGORIES OF PARTICIPANTS IN SITE VISIT DISCUSSIONS

Educational Institution	Health Care Agency
Chief Administrator/Chief Administrator for Allied Health Programs	Chief Administrator
Financial Administrator	Financial Administrator
Department Head(s)/Program Directors	Director of Training/Clinical Affiliations (Comprehensive)
Faculty	Chiefs of Services/Departments/Units Providing Affiliations
Didactic	Education Program Directors
Clinical Coordinators	Educational Coordinators
Students	Clinical Instructors
	Students

INTERACTION WITH PROFESSIONAL ASSOCIATIONS

Three types of contacts were made with professional associations influential in allied health and clinical education. Early in the effort, an announcement of the study was sent to all potentially concerned organizations, which also solicited their opinions and other input. In a corollary step, allied health publications and those in related fields were requested to announce the study. A presentation on the study was made at the annual meeting of the Association of Schools of Allied Health Professions held in Houston in November 1972.

The second type of contact occurred in January 1973, when the Bureau of Health Resources Development sponsored a forum for selected association representatives. The forum was an opportunity to present substantive details on the study investigations, including specific issues and anticipated results. Association reactions were requested at the forum and in a follow-up communication. Opinions were solicited on the following points:

- What do you see as major problems in clinical training for your field?
- How urgent is it to attack these problems?

- What approaches to solving these problems do you suggest?
- What role has your organization played in solving the problems? What do you envision your future role to be?
- Should the Federal Government have a role in this problem solving? As a provider of funds? In some other capacity?

Organizations in attendance at the forum are listed in Exhibit C-I, following this page.

The most detailed contact consisted of contributions by the associations and discussions with their representatives. Associations providing this type of input also are indicated in Exhibit C-I. These discussions focused on the following areas in addition to those outlined above:

- Objectives of the organization, particularly with respect to clinical education
- Organization, operation, and financing of education activities and financing mechanisms

EXHIBIT C-I

PROFESSIONAL ASSOCIATIONS
PROVIDING INPUT TO STUDY

Association	Type of Input: Participation in Forum	Type of Input: Contribution of Opinions/Information
American Academy of Physical Medicine and Rehabilitation	x	x
American Association of Blood Banks	x	x
American Association of Community and Junior Colleges		
American Association of Medical Assistants	x	x
American Association of Respiratory Therapy	x	x
American Association of State Colleges and Universities	x	x
American Board of Certification in Orthotics and Prosthetics	x	x
American College of Radiology	-	x
American Corrective Therapy Association	x	x
American Dietetic Association	x	x
American EEG Society	-	x
American Hospital Association	x	x
American Medical Association	x	x
American Medical Records Association	x	x
American Medical Technologists	x	x
American Nursing Home Association	x	-
American Occupational Therapy Association	x	x
American Optometric Association	x	x
American Pharmaceutical Association	x	x
American Physical Therapy Association	x	x
American Society for Medical Technology	x	x
American Society of Anesthesiologists	x	x
American Society of Clinical Pathologists	x	x
American Society of Electroencephalography	x	x
American Society of Radiologic Technologists	-	x
American Speech and Hearing Association	-	x
Association of Operating Room Technicians	-	x
Association of School of Allied Health Professions		x
Federation of Regional Accrediting Commissions on Higher Education		
International Society of Clinical Laboratory Technologists	x	x
National Committee for Careers in the Medical Laboratory	x	x
National Medical Association	x	x

GLOSSARY OF TERMS

Accreditation--The process by which an agency or organization evaluates and recognizes a program of study or an institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study or their services.

Administrator--A person whose primary work is the management or administration of an institution or one of its major areas of activity, such as all allied health programs or all clinical training; may refer to persons based in either health care agencies or educational institutions.

Affiliating Agency--The institution closely associated with the agency sponsoring an allied health educational program that provides part of the requisite learning experiences; usually a health care agency which provides the practicum.

Affiliation--An arrangement established between a sponsoring agency and an affiliating agency for the latter to provide a portion of the education, usually the clinical or practicum segment.

Articulation--A process which, at least, provides a continuous flow of students from grade level to grade level and from school to school. Implicit in this process is the need to systematize the activities influencing student progress. In its broadest definition, articulation also refers to the interrelationships between schools and colleges, quasi-education institutions, and other community organizations--all activities that affect the movement of the student.

Certification--The process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Challenge Examination--Equivalency testing which leads to academic credit or advanced standing in lieu of course enrollment by candidate.

Clinical Coordinator--An educator whose primary responsibility is ongoing communication with health care agency affiliations in support of clinical education.

Clinical Education--That part of the continuum of education of health workers which prepares the student for the function he will perform in the direct satisfaction of the needs of a patient, consumer, or community being provided with health care services. Clinical education, which also may be referred to as specialized education, can be taught didactically or by practicum.

> Didactic--Student learning the content of the above by means of lecture, seminar, demonstration, or laboratory exercises.
>
> Practicum--Student learning the above in a setting in which patients are actually receiving care or by being assigned certain functions specific to his professional field, under supervision and with graded responsibilities--the goal being to enable him to perform these functions competently, that is, to make the decisions about when and how to perform these functions and to understand the basis for his action.

Clinical Staff--Health practitioners whose principal employment is within a health care agency.

Clinical Training--Used interchangeably with Clinical Education.

Clinician--Generally used synonymously with Clinical Staff; may also refer to independent health practitioner.

Clinical Educator, Clinical Instructor, Clinical Supervisor--Staff member of a health care agency who is responsible for clinical education experiences, instruction, and/or the supervision of student practice.

Competency--The minimum capability needed by an allied health practitioner to provide safe, humane health service.

Curriculum--The sum total of courses and other instructional requirements followed by a student during his college years.

Developmental Sources--Learning experiences directed to providing a student with the basic capabilities he requires to succeed in more specialized education.

Education--The process of developing skills, knowledge, and attitudes; used synonymously with training.

Educational Expert--An individual who is specially trained in pedagogical methodologies and techniques but may or may not have expertise in health fields.

Educator--A person whose principal employment is within an institution of postsecondary education and whose primary responsibility is the provision or support of instruction; may be an instructor, clinical coordinator, counselor, etc.

Equivalency Testing--Comprehensive evaluation of knowledge acquired through alternate learning experience as a substitute for established educational requirements.

Essentials--Criteria adopted by an accrediting agency for specialized program accreditation, to serve as the legal basis for regulating the quality of educational programs; any requirement to which a program is held accountable should be included in the essentials.

General or Nonclinical Education--That portion of the continuum of education of health practitioners in which the student learns the language and skills which will enable him to learn optimally in his clinical education and will support his personal development. At a minimum the "language" includes the basic sciences pertinent to his field, as well as such elements of the humanities and social sciences as are requisite foundations for specialized learning.

Guidelines--Explanatory material developed to assist in the interpretation of the essentials.

Health Care--The spectrum of preventive, acute, therapeutic, rehabilitative, and chronic care and services provided by hospitals and other such health services activities.

Health Service--Used synonymously with Health Care.

Independent Expert--Used synonymously with Resource Person.

Institutional Accreditation--Refers to the process by which an educational institution is evaluated and recognized as meeting predetermined qualification or standards.

Licensure--The process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title or grants permission to institutions to perform specified functions.

Occupation--The principal activity of one's life; specifically, any of the allied health manpower fields which are of interest to this study.

Performance/Practical Exam--Test in which an individual demonstrates knowledge and/or skill through completion of designated activities resulting in stipulated outcomes.

Proficiency--Thorough competence derived from practice, education, and experience.

Proficiency Testing--The measurement of an individual's competency to perform at a certain job level, a competency made up of technical knowledge and skills and related to the requirements of a specific job. Such testing is therefore not only a measure of the knowledge gained through organized instruction or informal means but also an assessment of job capabilities.

Program Director--A person who is responsible for the administration and operation of an educational program; the program may be based in an educational or health care institution:

Qualifying Examination--Criterion for measuring an individual's ability to meet a predetermined standard.

Resource Person--A person contacted because of his expertise in one or more health-related areas; may be an educator, clinician, or staff member of a professional association, governmental agency, or private organization.

Specialized Accreditation--Refers to the process by which allied health programs of study are evaluated and recognized as meeting predetermined standards.

Sponsoring Agency--The institution, either educational or health care, which assumes primary responsibility for an allied health educational program.

Standards--Used synonymously with Essentials.

Unit--Refers to a department or service area in a health care agency.

Validation Examination--Used synonymously with Challenge Examination.

POSITION STATEMENTS ON ALLIED HEALTH CREDENTIALING

The stated positions on allied health credentialing of eight major organizations are reflected in the statements on the following pages:

- Accreditation and Institutional Eligibility Staff, Office of Education, DHEW
- American Hospital Association
- American Medical Association
- Association of Schools of Allied Health Professions
- Division of Allied Health Manpower, Bureau of Health Resources Development, DHEW
- Division of Medical Care Standards, Health Resources Administration, DHEW
- Federation of Regional Accrediting Commissions on Higher Education
- National Commission on Accrediting

These statements were developed through the joint efforts of the study team and executive staff of the concerned organizations. They may not represent the official positions of the private organizations since Board of Director approval was not sought.

POSTURE OF THE ACCREDITATION AND INSTITUTIONAL ELIGIBILITY OF STAFF, BUREAU OF HIGHER EDUCATION OFFICE OF EDUCATION, DHEW*

While not involving itself directly in analysis of specific accreditation standards, the Office of Education is concerned that accrediting agencies adhere to such principles as independence of judgment; self-evaluation by applicant institutions or programs; securing of qualitative data; acceptance of standards, methods of evaluation, and decisions by appropriate constituencies; enforcing of ethical practices among accredited institutions or programs; periodic review of standards; and responsibility to the public.

The U.S. Commissioner of Education has published Criteria for Nationally Recognized Accrediting Agencies and Associations for use as an analytical tool in fulfilling the Commissioner of Education's legislative mandate to publish a list of nationally recognized accrediting agencies and associations which he has determined to be reliable authorities concerning the quality of education or training offered by educational institutions or programs, for the purpose of determining institutional eligibility for participation in certain Federally sponsored programs of assistance to education.

In accordance with the policies of the Office of Education to review regularly the accrediting agencies listed by the Commissioner of Education and to review agencies which seek the extent the scope of their recognition by the Commissioner, the Council on Medical Education, AMA, and its collaborating agencies were reviewed in April 1972. The Commissioner of Education communicated his decision to the Council on July 10, 1972, based upon the findings and recommendations of his Advisory Committee on Accreditation and Institutional Eligibility and is awaiting the Council's response to his decision. The Council's reply will be reviewed in December 1973.

*Prepared by John R. Proffitt, Director, Accreditation and Institutional Eligibility Staff.

POSTURE OF THE ACCREDITATION AND INSTITUTIONAL ELIGIBILITY OF STAFF, BUREAU OF HIGHER EDUCATION OFFICE OF EDUCATION, DHEW*

A major issue identified by the Office of Education for further discussion by the Council related to the proliferation of allied health education accreditation activities. Other issues relate to the public accountability of the Council as an umbrella agency and to the effectiveness of the Council as a determiner of educational quality.

POSTURE OF THE AMERICAN HOSPITAL ASSOCIATION*

The AHA is very sympathetic to the SASHEP recommendations, but has expressed concern about how the proposed mechanism will be financed.

The Association's current position on accreditation is in a state of flux while the Association works with the Council on Medical Education in this area.

The AHA recommends representation of Allied Health groups on a Liaison Committee on Allied Health Education.

The AHA has no official policy statement on certification because it is a voluntary procedure. However, it supports a national study on certification such as the one now sponsored by BHME.

Further licensure will fractionalize the provision of health services and impede job advancement.

The AHA recommends a plan with short- and long-range aspects, which include:

- Moratorium on additional licensure
- Establishment of a National task force to study licensure and make recommendations
- Adoption of interim relief actions such as establishing equivalency and proficiency measures as alternatives to licensure, and developing criteria for new licensure statutes

*Prepared in conjunction with the Bureau of Manpower and Education, American Hospital Association.

POSTURE OF THE AMERICAN MEDICAL ASSOCIATION*

The Association does not wish to control the accreditation of allied health programs as reflected in its current proposal for the Establishment of a Liaison Committee on Allied Health Education.

Physicians should be involved in accreditation of allied health programs, including the development and revision of standards and the conduct of accreditation visits.

Accreditation should remain a nongovernmental function.

Quantitative specifications of duration should be eliminated from essentials.

Essentials and guidelines should be more oriented to the development of competency, e.g., through the inclusion of behavioral objectives.

There is no AMA position on certification which is the prerogative and responsibility of professional associations.

Licensure of allied health professionals is not a desirable credentialing mechanism.

*Prepared in conjunction with the Department of Allied Medical Professions and Services, American Medical Association.

POSTURE OF THE ASSOCIATION OF SCHOOLS OF ALLIED HEALTH PROFESSIONS*

ASAHP fully endorses the SASHEP findings directed to establishing a mechanism to enhance parity throughout the accreditation process specifically an independent agency including the AMA, and the Allied Health professions.

Physicians should be involved as representative members of the accrediting team, not however with the power of veto.

ASAHP is opposed to government, through USOE, assuming a lead role in accreditation. However, the financing of an independent accrediting body is of critical significance.

Allied Health professions are not generally ready for licensure.

There is a tremendous need for increased communication, collaboration, and coordination among Allied Health professions.

The present objective of ASAHP is to develop a tentative plan for accreditation to be implemented over a 3 to 5-year period and discontinued if proven ineffective after a trial time period. This would eliminate a note of finality and encourage conditional acceptance of innovative procedures.

*Prepared in conjunction with the Executive Director, Association of Schools of Allied Health Professions.

POSTURE OF THE DIVISION OF ALLIED HEALTH MANPOWER BUREAU OF HEALTH RESOURCES DEVELOPMENT, DHEW*

The Division of Allied Health Manpower supports the development of a proficiency testing mechanism for health manpower.

Equivalency examinations do not adequately serve the needs of many health workers.

National credentialing systems for allied health professions should be promoted without compromising the basic standards.

The credentialing system should be largely or wholly self-sustaining after the initial development.

Standards should be developed which allow maximum mobility within and between professions and alleviate career barriers in the health field.

Proficiency standards should be developed based upon the knowledge and skills deemed necessary to perform a given role or function within the health system.

A panel of experts representing employers, specialists, educators, regulatory agencies and consumers should determine these standards.

Graduation from an accredited educational program is a satisfactory credentialing mechanism.

Proficiency standards should be developed as a joint venture with appropriate professional associates.

Credentialing of allied health manpower should be not for profit.

*Formerly the Bureau of Health Manpower Education; prepared in conjunction with the staff of the Division of Allied Health Manpower.

POSTURE OF THE DIVISION OF MEDICAL CARE STANDARDS, HEALTH RESOURCES ADMINISTRATION, DHEW*

Federal regulations for judging the professional competency and qualifications of selected types of health care personnel to participate in the Medicare program have been based on expert judgment by various expert committees and review of the following:

- Licensure
- Normal education and formal training courses
- Membership, registration/certification by certain specialties of professional organizations

The 1972 Social Security amendments include provision for development and use of a proficiency testing program to determine the qualifications of selected types of non-professional health workers for Medicare and Medicaid participation. This change is designed to provide a significant increase in qualified personnel in these occupations.

Thus in attempting to assess health personnel qualifications, the Division utilizes credentialing for higher skill level professions, will begin to utilize proficiency testing for selected occupations of lesser skill, and relies quite heavily on direct supervision by a qualified person for lower worker levels where there is no credentialing mechanism available.

*Formerly the Health Services and Mental Health Administration; prepared in conjunction with the Director of the Division of Medical Care Standards.

POSTURE OF THE FEDERATION OF REGIONAL ACCREDITING COMMISSIONS ON HIGHER EDUCATION*

Overlap and duplication of general and specialized accreditation should be eliminated.

Each institution should be free to decide whether specialized accreditation of programs serves its needs.

Regional accrediting agencies will collaborate with special experts to review special programs as part of the general accreditation upon request by the institution.

Institutions are encouraged to review their position on the total accreditation patterns to determine whether they desire specialized accreditation.

*Extracted from a resolution adopted on October 14, 1964, by the Federation of Regional Accrediting Commissions on Higher Education.

POSTURE OF THE NATIONAL COMMISSION ON ACCREDITING *

Specialized accreditation is an acceptable public protection device.

Physician involvement in specialized accreditation is desirable but control by any one profession is unacceptable.

The same standards must be applied to public and proprietary educational institutions.

The major problems in specialized accreditation are:

- The tremendous proliferation of separate accreditation activities
- The differences in requirements of various accreditation activities

*Prepared in conjunction with the Executive Director, National Commission on Accrediting.